

Michigan Department of Human Services Bureau of Children and Adult Licensing	FOR BCAL USE ONLY	
HOMES FOR THE AGED APPLICATION FOR LICENSURE	Receipt Date	License Number

SECTION I - FACILITY INFORMATION

TYPE OF APPLICATION					
INITIAL		CHANGE OF OWNERSHIP		APPLICATION INFORMATION UPDATE	
1. Facility Name	2. Main/Public Telephone No.	3. Fax Number		4. E-Mail address	
5. Facility Street Address	6. City/Village/Township	7. State Michigan	8. Zip Code	9. County	
10. Facility Mailing Address (if different than #5)		11. City	12. State	13. Zip Code	14. County
15. Number of Beds to be Licensed		16. Administrative/Emergency Phone No.		17. Program <input type="checkbox"/> Aged <input type="checkbox"/> Dementia/Alzheimers	

SECTION II – APPLICANT/LICENSEE/OWNERSHIP INFORMATION

18. Owner/Company (legal entity that owns facility)			19. Federal I.D. Number		
20. Owner/Company Street Address	21. Owner/Company City	22. State	23. Zip Code	24. County	
25. Mailing Address (if different than #21)	26. City	27. State	28. Zip Code	29. County	
30. Full Name of Individual Owner or Person with Legal Authority to Act on Behalf of Company					
31. Social Security #		32. Owner/Company Telephone ()		33. Fax Number ()	
34. Type of ownership: <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Non-Profit Church <input type="checkbox"/> Non-Profit Other <input type="checkbox"/> Other (specify) _____					

SECTION III – CORPORATION OFFICERS/DIRECTORS/TRUSTEES (Attach additional pages if necessary)

NAME	TITLE	ADDRESS (City, State, Zip Code)

SECTION IV – LIST ALL PERSONS WITH OWNERSHIP INTEREST (Attach additional pages if necessary)

NAME	ADDRESS (CITY, STATE, ZIP CODE)	PRINCIPAL OCCUPATION	OFFICIAL POSITION

SECTION V – AUTHORIZED REPRESENTATIVE

An authorized representative shall be appointed and have and agree to the following authorities relative to licensure: submit applications and amendments, provide all requested information to the department, enter into agreements with the department, receive notice and service in matters relating to licensure.

35. Name of Designee	36. Social Security #	37. Phone Number	38. Alternative Phone Number (Optional)
39. Effective Date	40. Certificate of Appointment Attached		

SECTION VI – ADMINISTRATOR

41. Name of Administrator (if known)	42. Social Security #	43. Date of Birth
44. Phone Number	45. Alternative Phone Number (Optional)	

SECTION VII – CERTIFICATION AND SIGNATURES

The applicant certifies that he/she has read 1978 PA 368, as amended, and the Administrative Rules (325.1801 through 325.1891) regulating the operation of Homes for the Aged facilities. If granted a license, I will comply with the Act and these Rules.

Failure to submit accurate and complete information in a timely manner may result in denial of licensure. An applicant who makes a false statement in this application is subject to criminal penalties under Section 20142(5) of the Public Health Code (1978 PA 368).

The applicant certifies that the information provided on this application is true, complete and accurate to the best of his/her knowledge.

The applicant certifies that, in compliance with the Administrative Rules, notification within 5 business days will be given to the Department for any changes to the information contained in this application. For an administrator change, the notification must include the new administrator's name, social security number, date of birth, phone number, qualifications, the effective date of appointment, the facility name, address, and license number.

46. Applicant Name/Authorized Representative (print or type)	47. Applicant/Authorized Representative Telephone No.
--	---

48. Applicant/Authorized Representative signature	49. Date
---	----------

The Department must be notified within five (5) business days of any changes submitted on, or with, this application – R325.1813(2).

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.	AUTHORITY: 1978 PA 368 of 1978 COMPLETION: Mandatory NON-COMPLETION: License issuance will be denied.
---	---